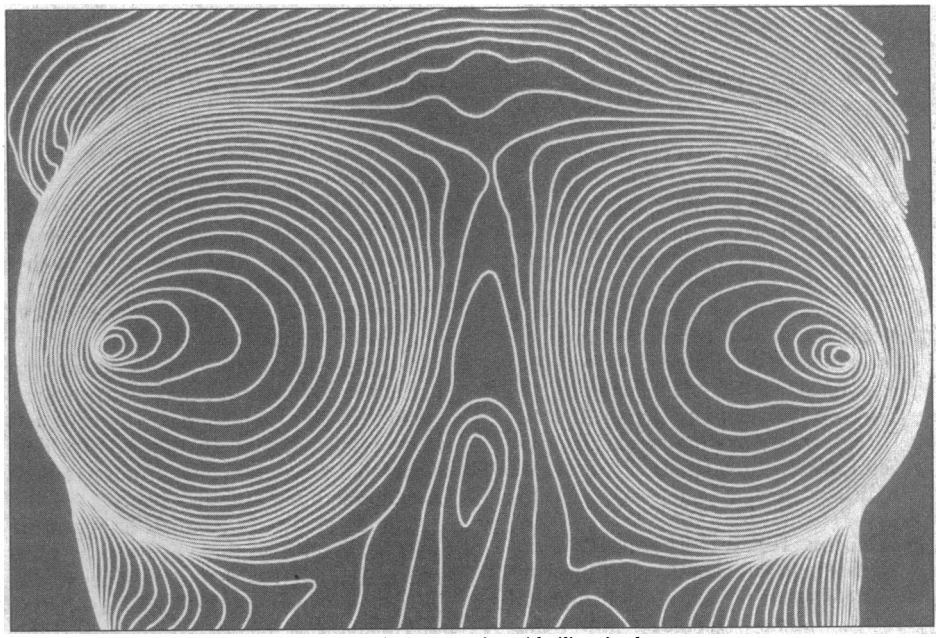
FDA says breast implants are probably safe . . .



ROBIN WILLIAMS/SCIENCE PHOTO LIBRARY

How breasts look on a contour map after cosmetic augmentation with silicon implants

An advisory committee to the Food and Drug Administration recommended last week that silicone breast implants remain on the market in the US despite a lack of data showing them to be safe. Bags of silicone gel have been implanted in more than 2 million American women in the past 30 years for breast replacement after cancer surgery or, far more commonly, for breast augmentation. Because the implants predate the 1976 medical devices law requiring proof of safety and effectiveness they have remained on the market even though the FDA has never approved them.

In recent years, organisations of women who have suffered adverse consequences from the implants have demanded that the FDA remove the devices from the market. Public Citizen Health Research Group, an organisation founded by consumer advocate Ralph Nader, estimated from a sample surveyed by the American Society of Plastic and Reconstructive Surgeons that 155 500 women have had problems with ruptured implants or infections, 123 300 others have hardened breasts, and more than 250 000 find the implants uncomfortable.

The American Medical Association, the American Cancer Society, and former cancer patients, however, vigorously defended the implants as vital to restoring women's self image after mastectomy. "We're not talking vanity here," said Sheila Profiter of San Francisco, whose implant helped her feel "whole again." Representatives from the AMA and the cancer society argued that there was no evidence that the implants would cause health problems.

Four manufacturers of breast implants—Dow Corning Wright, Mentor, McGhan Medical, and Bioplasty—presented animal and clinical studies to the panel to show that their products were safe. By a 9:1 vote, however, the panel rejected the data as insufficient to reach that conclusion—even on Dow Corning's two implants, Silastic II and Silastic MSI, on which the most evidence had been submitted. The lack of information was "appalling," the panel said.

None the less, on the third day of the hearing the panel concluded that there was a "public health necessity" for silicone breast implants, both for reconstruction after surgery and for breast augmentation. It recommended that the FDA should allow the devices to remain on the market—as previously without specific approval—while the manufacturers continue studies to produce the necessary data on short and long term safety. Meanwhile, women should be given more information on the risks and benefits before they undergo implant surgery.

FDA commissioner Dr David Kessler has until 6 January to decide whether to accept the panel's recommendations. "I was struck by the lack of data," he said after the hearing. "In 1991, after 30 years of use, we really still don't have the data. No matter what, we need to get to the bottom of this."—REX RHEIN, medical journalist, Washington, DC

. . . so does Canada

An expert panel coordinated by the Canadian Medical Association has concluded that there is no need for surgical removal of polyurethane covered breast implants solely because of a potential cancer risk. The panel did not undertake a quantitative assessment of the carcinogenic risk caused by 2,4-toluene diamine (TDA), one of the products that can result from breakdown of the polyurethane. But the Canadian panel reviewed an assessment made in June by the US Food and Drug Directorate and agreed with its conclusion that the estimated increase in lifetime risk of breast cancer was of the order of five cases per 10 million women with two implants.

Despite its conclusion the panel reported that further research is needed on the efficacy and long term safety of such implants—particularly on their carcinogenicity, mutagenicity, and teratogenicity. It also suggested establishing an implant registry. The panel's statement was attacked by a group called I Know/Je Sais representing women who have breast implants, as being ambiguous in suggesting that the devices are safe while calling for more research.

The panel was convened at the request of the national health and welfare department, but its conclusions do not necessarily represent the opinions of either the department or the association. The panel was set up in response to a long controversy over one such implant, the Meme. The Meme was withdrawn by its manufacturer from the market in both the United States and Canada last April, but there have been reports that some were implanted from stocks even after the withdrawal. Some 17 000 Canadian women have been fitted with the implant, 12 000 of them in Quebec.—DAVID SPURGEON, scientific and medical journalist, Quebec

NAHAT survey

In the second part of its annual autumn survey the National Association of Health Authorities and Trusts (NAHAT) has examined the financial position of purchasers and providers in the first year of the new NHS management and funding arrangements. Not unexpectedly, differing interpretations are being placed on the findings. The prospect of balanced budgets combined with increased activity is a pleasing one for both the government and health authorities. To the informed outsider, on the other hand, the most striking feature is likely to be the difference in the effect of the broadly similar findings on the purchasers (health authorities)

Headlines

Ban on abortion counselling in US: Doctors at family planning clinics funded by the American government may soon have to stop telling pregnant clients that abortion is a legal option. Congress tried to void this rule, but last week President Bush vetoed its decision and the House of Representatives failed by 12 votes to overturn his veto.

Drop in Dutch AIDS cases: The reported incidence of AIDS in the Netherlands has fallen for the first time. There were 191 notifications in the first half of 1991 compared with 213 in 1990.

Reducing animal testing: At the first international conference on the harmonisation of animal testing the European Community, Japan, and the US agreed to stop duplicating pharmaceutical tests on animals. This should reduce the total of such tests by a third.

Helping former hostages: The Department of Health is to provide £70 000 a year for two and a half years to the trauma psychology unit at the Middlesex Hospital, London. The unit complements one at the Maudsley Hospital, London, and will treat victims of post-traumatic stress disorder, including former hostages.

Medical education network: People who want to join a new network to learn about, assess, and debate current changes in medical education should contact Dr Angela Towle, King's Fund Centre, 126 Albert Street, London NW1 7NF.

***BMA News Review* wins prize:** The BMA's monthly membership magazine came second in the category of best corporate magazine in last week's Magazine Publishing Awards and was praised for its high standard of journalism.

Firearms deaths in Texas: According to the Texas Department of Health, 3443 people were killed by guns in 1990, compared with 3309 who were killed in car accidents. Texas is the first state to report to the federal Centers for Disease Control that gun deaths outnumbered traffic deaths last year.

Radon in Scotland: According to the National Radiological Protection Board, the average concentration of, average annual dose of, and range of exposure to radon in Scotland are lower than elsewhere in the United Kingdom. But radon in some 2000 Scottish homes may exceed the government's action level of 200 Bq/m^3.

and the providers (directly managed units and trusts).

Nearly all purchasers consider this year's allocations sufficient to meet contractual obligations. Four fifths admit that they have experienced problems with operating contracts, but these problems are mostly confined to issues that should not affect their eventual budgetary position—billing procedures, late notification of allocations, and higher than expected activity.

The response rate among providers (29%) was lower than for health authorities (54%), and non-response bias must be a possibility. All respondents expect to balance income with expenditure this year, but two thirds expect to have to take actions to achieve this, such as efficiency savings additional to those already included in contracts and restrictions on activity. Under block contracts higher than expected levels of activity represent a problem for providers in that the fees payable for a defined range of services have to cover more patients than intended. In the circumstances it is not surprising that most providers intend to change to cost and volume contracts whose impact is less disruptive. Providers also intend to secure more contracts with general practitioner fundholders.

Looking at the distribution of contracts, NAHAT found that three quarters by value have been placed with the provider's local district, a position that the association describes as working to a "steady state." This balance may well change; 7% of purchasers, for example, have declared their intention to negotiate contracts with providers where considerable extracontractual referrals are occurring.

Some of the most telling figures turned up by the survey may well prove to be the estimates of pay and price inflation made by respondents. At a weighted average of 6·5% and 5·6% respectively these are well above the rate underlying the government's expenditure plans and could yet frustrate these.

—JON FORD, head, economic research unit, BMA

Autumn Survey of the Financial Position of Health Authorities and Trusts is available from the National Association of Health Authorities and Trusts, Birmingham Research Park, Vincent Drive, Birmingham B15 2SQ.

German haemophilic patients infected with HIV

Ten recently diagnosed cases of HIV infection in Germany were probably caused by a commercially produced blood clotting preparation used mainly to treat haemophilia. The preparation, PPSB (prothrombin, proconvertin, Stuart factor, and antihaemophilic globulin B), was made by a German producer Biotest Pharma GmbH of Frankfurt and withdrawn from the market in April last year. Biotest has already settled out of court with most of the patients infected. Two of the 10 patients were given PPSB for indications other than haemophilia and were not routinely tested for HIV antibodies—their infections were detected more or less coincidentally. And, according to a report on 14 November in the news magazine *Stern*, many more patients may have been infected.

In the early '80s in Germany about 2000 haemophilic patients who had been treated with factor VIII concentrates became infected with HIV. At that time 90% of donor blood for such preparations was imported from the United States. When the link between clotting factors and HIV infection became evident in 1985 contaminated products were removed from the market. Manufacturers and patients' organisations agreed an extrajudicial settlement in 1987, which guaranteed compensation of up to DM 500 000 (£170 000) to most haemophilic patients infected by HIV in Germany.

From 1985 the German federal health office (Bundesgesundheitsamt) licensed only preparations that had been either heated to 70° C or treated by cold sterilisation, a process combining the effects of ultraviolet radiation and propiolactone. The advantage of cold sterilisation is that it destroys much less of the clotting factor than does heating and therefore makes production more cost effective. Only Biotest, however, used cold sterilisation in producing PPSB.

All haemophilic patients treated with clotting factor preparations were regularly and routinely tested for HIV antibodies from 1985. In the early 1980s eight patients were found to be HIV positive and investigation soon led to Biotest's PPSB. All eight infected patients had been treated with the same batch, numbered 1601089. Some 40% of the donor blood in lot 1601089 came from the US, and six of the American donors had been found to be HIV seropositive at follow up. The similarity of HIV types isolated from the blood of seven of the patients also suggests a common source of infection, according to Dr Hans Hermann Brackmann from the Bonn Haemophilia Centre.

Virologists from the Paul Ehrlich Institute

MANSELL COLLECTION

Haemophilia has been a problem in Germany for years. The family of Louis IV (shown here) passed on the disease to the Romanovs in Russia

in Langen near Frankfurt have found that cold sterilisation is not sufficient to eliminate HIV from highly contaminated plasma. In April 1990 the federal health office revoked the production licence for PPSB and Biotest recalled all remaining batches.

Six of the patients or their parents have received compensation of at least DM 155 000 (£50 000) each, although, as Biotest sales manager Peter Pustoslemsek still insists, "there is no proof that PPSB can be blamed for these AIDS cases."

Other observers, such as pharmacologist Professor Peter Schönhöfer from the University of Hannover, fear that PPSB could be blamed for more than the 10 cases known so far. Schönhöfer is demanding that all patients treated with lot 1601089 should be tested for HIV infection as soon as possible. This would mean checking the records of thousands of patients—an effort for which nobody is yet ready to pay.—HELMUT KARCHER, science writer, Munich

MIKE ABRAHAMS/NETWORK

Competitive tendering: today laundry, tomorrow management?

The future for competitive tendering

With assurances that the government is committed to a publicly funded health service "firmly located in the public sector" Francis Maude, the financial secretary to the treasury, recently launched a new white paper aimed at extending competition throughout NHS support services. The white paper, *Competing for Quality*, has been linked to the Citizen's Charter and proposes to "test" elements of publicly delivered services in the market. And it is services provided by central and local government and the NHS which are the main targets of this exercise in competitive tendering.

The NHS already spends around 9% of its budget on contracts with the private sector—equivalent to £1.3bn. About a fifth of total domestic and cleaning expenditure goes to private firms, for example. And in 1989-90, around £81m was paid to the private sector to provide direct services for patient care.

Competitive tendering has occurred in certain NHS support services for more than seven years, and the government reckons that in that time there have been savings of nearly £630m. The government believes, however, there is scope for increased tendering of services such as laundry and catering, and also for tendering of support services that have not yet been subject to market testing.

Health authorities and provider units will be encouraged to set themselves targets for testing their support services against potential alternative suppliers and to report on their achievements. In addition a new national database of contractors is to be established. Nationally, the treasury is to set up a Public Competition and Purchasing Unit to be led by a part time chair from the private sector.

Although competitive tendering in the NHS is not new, the consequences for the health service of this extension in the market testing initiative are potentially far reaching. While the NHS may remain funded largely from the public purse it is not clear where the line is to be drawn in defining support services, and hence the extent to which provision could end up in the private sector.

Could the management of hospitals be put out to tender, for example? To a certain extent this has happened already and, as the recent failure of the management buy out of the West Midlands Regional Health Authority's management services department (renamed Qa Business Services Ltd) shows, not always with much success. Potentially, extending the competitive tendering process could leave large chunks of the NHS not in the public sector, as Francis Maude maintains, but in the private sector, albeit under contractual obligation to the NHS.

Moreover, on the basis of the aims of the white paper, there would seem to be no logical objection to competitive tendering for clinical services which, semantics about privatisation aside, at best suggests some considerable blurring of the private/public sector divide.—JOHN APPLEBY, economic correspondent, *BMJ*

MRC delays plans to charge for genome data

Plans by the Medical Research Council (MRC) to charge commercial users for access to information generated by the human genome project in the United Kingdom have been scuppered, or at least put on ice. This follows the news that Craig Venter and colleagues at the American National Institutes of Health (NIH) have filed patent applications covering their collection of 337 sequences of complementary DNA (cDNA) (23 November, p 1286).

This cDNA represents sequences from the 5% or less of the human genome that codes for protein. As such, they are a rich resource for researchers in both academia and industry, who are beginning to dissect the genetic components of human biology and disease. Thus, although most of the roughly 4000 cDNA sequences amassed so far by the NIH and the MRC are just fragments of genes whose functions are unknown, the sequences are potentially hot property.

The MRC's plan involves charging each commercial user an annual subscription fee of £5000 for access to all the facilities and services (not only the cDNA sequences) available at its Human Genome Resource Centre at Northwick Park. The centre's director, Tony Vickers, likens the set up to a club. The annual fee would entitle commercial "members" to use many of the facilities of the "club" (such as databases), but additional charges would be levied for high cost services such as screening clone libraries. No charge would be made to academic users.

Industry leaders, about 30 of whom were consulted in a meeting organised by the MRC last month, are relaxed about the proposal, according to Vickers, who sees the scheme as an equitable way of disseminating the fruits of human genome research. No user would be able to remove any materials or information from the resource or restrict its availability to others. The nature of each inquiry would be kept confidential for a period of perhaps six months or until publication.

The future of the MRC's plan seems highly uncertain. A genome resource club along the lines proposed is obviously incompatible with the patenting of any of the facilities it might offer—a route that the MRC might be forced to follow if any such patents are granted in the US. On the other hand, the plan has aroused the ire of many who are opposed to any restriction of access to the results of human genome analysis, especially as the MRC intends to keep its cDNA database closed until the current situation is resolved. Vickers believes that the solution may lie in a government level international convention on sharing data in the human

genome project. Whatever the answer, it will have to come quickly if the much vaunted project is not to fall at the first practical hurdle.—ALISON STEWART, editor, *Trends in Genetics*

Sexual politics of the heart

Coronary heart disease kills almost as many women as men in the United Kingdom each year, and in 1989 led to the deaths of more women under 65 than did breast cancer. Last week the National Forum for Coronary Heart Disease Prevention held a meeting aimed at increasing awareness and proposing action to prevent the disease in women.

The proposals that emerged from the mixture of science, politics, and consciousness raising focused on measures to counter the slower decline of smoking among women and the higher rates of smoking among teenage girls; on pushing for a national nutrition policy; and on changing the title of the Sports Council into something less macho "that didn't suggest large bags full of expensive sticks to hit things with."

Speaker after speaker referred to the lack of data on women's cardiovascular health. David Wood, professor of clinical epidemiology at the National Heart and Lung Institute, speaking about the role of lipids in coronary heart disease, said that there were "no experimental data on women whatsoever. We don't know when or how to intervene . . . in women."

One problem for epidemiologists is the size of the studies needed to show effects on the risk of coronary heart disease in women. Professor Hugh Tunstall-Pedoe, director of the cardiovascular epidemiology unit at the University of Dundee, described a study of 36 000 men in the United Kingdom. To detect similar differences in risk among women would have required a study group of 1-2 million.

Hormone profiles are one subject in which sex differences are beyond dispute—although the widely accepted postmenopausal acceleration in rates of coronary heart disease was dismissed as a myth by Professor Tunstall-Pedoe. His logarithmic plot of coronary mortality in women in the United Kingdom showed no change in gradient around age 50.

Nevertheless, efforts to fine tune the balance of oestrogenic, progestogenic, and androgenic influences of hormone replacement therapy continue in what Dr John Stevenson, a consultant endocrinologist at Wynn Institute for Metabolic Research, described as an attempt to get an optimal ratio between risks (breast and endometrial cancer) and benefits (cardiovascular disease and osteoporosis). Individually women may welcome these efforts, but collectively they may be taken aback by Dr Stevenson's view that they are "hormone deficient for a third of their lives."

Any ideas of mass prophylaxis in postmenopausal women against atherosclerosis were scotched by Dr Klim McPherson, head of the health promotion sciences unit at the London School of Hygiene and Tropical Medicine. He said that the price per quality adjusted life year (QALY) of 10 years of hormone replacement therapy for a 50 year old woman (£6200) would not be much cheaper than a heart transplant (£7200).—JANE DAWSON, *British Heart Journal*

SALLY AND RICHARD GREENHILL

What should women do and not do to protect their hearts?

Prison policies on HIV under review

In March this year, in response to the Woolf report on prison disturbances, the prison medical service announced a review of controversial restrictions that allowed segregation of inmates with HIV and hepatitis B virus infections. Earlier this month the service started a full review of all prison policies on HIV and AIDS, emphasising inmates' need for "careful, thorough and sensitive screening and examination," health education, counselling, and care when infected.

The viral infectivity restrictions were introduced six years ago, when prison staff were highly anxious about the spread of HIV infection through Britain's prisons. These restrictions allowed prison staff to put infected inmates in separate accommodation and to bar them from sports and games. The rules also allowed limited breaking of confidentiality, so that prison and police staff with a "need to know" could be told that certain inmates were restricted while not actually being told whether HIV or hepatitis B virus (both of which were covered by the restrictions) was involved. Not surprisingly, the restrictions probably discouraged inmates from consenting to testing. Now the restrictions are considered to be unnecessary, and with other policies on infection in prisons they are set to change.

Education is the first and broadest priority of the latest review. Under an existing health education programme called "AIDS Inside" all prison staff should know already that the risk of being infected during day to day work is very small. They should now go on refresher courses every three years. All health care staff should know when and how to offer HIV testing that incorporates specialist counselling before and after the test and written consent.

Precautions to change high risk behaviour among inmates are to be stepped up, although they may not go far enough. As an absolute minimum all inmates will be given a leaflet by the AIDS charity the Terrence Higgins Trust (figure), and new inmates will be shown an educational video within four weeks of their reception. Explanation of high risk and safe behaviour will be included in all prerelease courses. Some prisons are already giving a small free supply of condoms to take home, but, according to a report by the director of the prison medical services, Dr Rosemary Wool, Home Office ministers "have not been convinced that making condoms available for use in prison would be appropriate or helpful." And, even though the service recognises that some inmates will gain access to injectable drugs and will share injecting equipment, needle exchange schemes in prison "cannot be contemplated."

Greater efforts will be made to give care and support to inmates infected with HIV. Recognising the considerable psychosocial burden of infection, the medical service recommends that such inmates should not be subjected to any special restrictions unless the prison medical officer thinks extra precautions are necessary. Discriminatory practices such as giving HIV positive inmates individual eating utensils will not be acceptable.

Infected inmates will be monitored and cared for by multidisciplinary teams and special key workers. Those inmates thought to need extra support from family, friends, and outside agencies should be able to meet them in private, probably in the prison health centre, to preserve confidentiality and avoid accusations of special privilege.—TRISH GROVES, *BMJ*

£437m up in smoke each year

People with smoking related diseases cost the NHS an estimated £437m a year, and at any time they occupy over 9000 NHS beds in the United Kingdom. These stark facts appear in *The Smoking Epidemic—Counting the Cost*, in which the Health Education Authority (HEA) gives a detailed breakdown for each region, district health authority, and local authority of the number of deaths attributable to smoking; the numbers of hospital admissions and of hospital beds taken up daily due to smoking; and the annual cost to the NHS of treating smoking related diseases. The evidence is published in 17 volumes covering the 14 English regions, Scotland, Wales, and Northern Ireland.

It is six years since the HEA released *The Big Kill*, which stated that "smoking is the largest single cause of preventable, premature death in this country." Although the number of adults smoking is falling at present, more teenagers smoke and there are 17 million smokers in the United Kingdom. An estimated 110 000 people die each year from smoking related diseases, but this figure could be an underestimate because it does not include the effects of passive smoking.

Manchester has the distinction of having the highest proportion of deaths due to smoking among district health authorities—smoking causes a fifth of the 3400 deaths annually in North and Central Manchester Health Authorities. In England the districts with the lowest figures are in the south; Maidstone in Kent with 14% (263 deaths) comes at the bottom.

The HEA's chief executive, Dr Spencer Hagard, said at the launch press conference earlier this week that 70% more women who smoked would die before the age of 65 than women who had never smoked and that smoking doubled the chances of men dying before 65. Yet cigarettes are still heavily advertised, cleverly promoted, and widely sold.

Dr Fleur Fisher, who heads the BMA's professional and scientific division, referred to the government's commitment in *The Health of the Nation* to targets of a smoking rate of 22% for men and 21% for women by 2000. This, she said, was attainable only if the government showed the political will to back up the green paper with comprehensive action, such as a total ban on the advertising of tobacco.

This ban is supported by the medical royal colleges and the Royal College of Nursing as well as the HEA, which has also called for a substantial increase in the price of cigarettes. It has set as its goal a minimum target of £3 for the cost of a packet of 20 cigarettes by 1995.—LINDA BEECHAM, *BMJ*

The Smoking Epidemic—Counting the cost is available from the Health Education Council, Hamilton House, Mabledon Place, London WC1H 9TX.

Promoting teenage friendly contraception

The "unfriendly" attitudes of general practitioners to young people asking for contraception may be contributing to the number of unwanted teenage pregnancies. A report by Isobel Allen, of the Policy Studies Institute, based on interviews with nearly 200 young people argues that some young people have unfavourable images of general practitioners and family planning clinics. What is more disturbing is that nearly three quarters of the teenagers interviewed were worried that the consultation would not be confidential.

"From the evidence we heard there are some young people who are refused contraception by their GP," says Isobel Allen. "But many GPs do provide a good service. Teenagers want to talk to someone who is kind to them."

The report looks at family planning projects funded by the Department of Health. Aimed at young people, the projects included outreach services which offered sex education to schools and youth clubs. "One of the most important recommendations the report makes is that family planning projects need publicity," says Isobel Allen. "This publicity needs to be professional and sustained. It needs to target boys as well as girls."

Isobel Allen's report comes a week after the announcement of a joint initiative between the Department of Health and the Family Planning Association to promote family planning. The Department of Health has given £200 000 to fund three projects aimed at increasing both public and medical awareness of unplanned pregnancies. Part of the money will go towards improving family planning in general practice.

"We know there are big differences between what general practices offer," says Karin Pappenheim, head of publicity at the Family Planning Association. "Some surgeries offer free condoms, but most GPs prescribe the pill rather than offer a wide range of contraception. Our first step is to set up needs assessment surveys in general practice."

The Family Planning Association intends to target the workplace, providing contraceptive "roadshows" for employees, and training in sex education for occupational health workers. The association's third initiative is the "Growing Up" project, which consists of a series of booklets providing information for parents, children, and young people. "We want parents to become better sex educators," says Karin Pappenheim. "Often they're not keen to teach because they're not sure of the facts. Sex education has to be set in the context of both biological information and feelings."

The motivation for these initiatives has come from several recent reports which have noted the rising rate of unplanned pregnancies among teenagers. A report by the Royal College of Obstetricians and Gynaecologists on unplanned pregnancies, published two months ago, emphasised the importance of sex education (14 September, p 604).

One of the alarming discoveries in Isobel Allen's study was that nearly half of the young people attending one of the project's clinics were seeking a termination of pregnancy.—LUISA DILLNER, *BMJ*

Family Planning and Pregnancy Counselling Projects for Young People by Isobel Allen is published by the Policy Studies Institute, 100 Park Village East, London NW1 3SR, and costs £17.95.

VICTORIA AND ALBERT MUSEUM

Smoking is everyone's problem

Late delivery of *BMJ*

We apologise to readers of the clinical research edition who last week received their *BMJ* late. This was due to problems at our distribution centre.

Nursing comes of age

The European debate and the impending Maastricht summit on economic and monetary union are dominating parliament almost to the exclusion of lesser issues, including the health service. Those of us who have become accustomed to a daily fix of health politics are suffering withdrawal symptoms.

They were hardly relieved by the single passing reference to health in the Eurodebate. It occurred when the Prime Minister made it clear that the government regards health issues as among those that should rightly be settled at national level. He said that it may be right for the European Community to complement national research programmes or collaborate in health campaigns, but the basic provision of health care should be a matter for the national government.

Not much there to satisfy Westminster's health junkies. Alternatively, those in search of excitement had to make do with the thin gruel of the only piece of health legislation in sight, the Nurses, Midwives and Health Visitors Bill, which has begun its passage in the House of Lords. The government proclaims the bill as marking a milestone in the history of nursing. Its main purpose is to change the constitution of the nurses' regulatory body, the United Kingdom central council. From being mainly appointed by the government the council will from 1993 have two thirds of its members elected, making the professions largely self regulating, while education and training will be devolved to health authorities.

The bill is so uncontroversial that Labour's new health spokesman in the upper house, Lord Carter, was able to congratulate the government on producing a health bill which was not contentious. The only reservations concern the scope of the new council's disciplinary powers and the protection of minority rights for the midwives.

The junior health minister, Lady Hooper, said that the bill represented "the coming of age" of the nursing professions, although it was their champion, Lady Cumberlege, who put its meaning in context. She said she supported the nurses, midwives, and health visitors "in their struggle to shake off the image of being angels or handmaidens. We know that they constitute a large, highly trained, and scrupulously monitored professional body."

A baroness who practised in all three disciplines, Lady McFarlane, reminded their lordships that the increasing sophistication of medical care had brought a commensurate need for sophistication in nursing care. Examples were the advances in oncology nursing, palliative care, and the work of midwives in special baby care units. Why then, it was asked, was the government so reluctant to introduce limited prescribing for nurses? The answer may come soon because, Mr Roger Sims came third in the ballot for private members' bills and is ready to legislate for nurse prescribing if the department supports the idea.

The competing attraction of the Europe debate left the health committee with barely a quorum to proceed with the neonatal phase of its inquiry into maternity services. But it was sufficient for the remaining MPs to ask if babies were dying because of a shortage of neonatal intensive care cots.

The expert reply was an emphatic "Yes," but the number was anybody's guess. For instance, doctors who after several attempts at finding a cot did not succeed would probably cover up by saying to the parents that they did not think that a transfer would help. They were not going to say that a lack of provision had caused the baby's death.

The committee was also warned that things could go from bad to worse, with considerable implications for medical staffing when junior doctors' hours were limited to 72 and consultants did not accept on call responsibilities. Professor David Hull, president of the British Paediatric Association, forecast a need for almost double the number of senior house officers. The alternative was the closure of neonatal units.—JOHN WARDEN, parliamentary correspondent, *BMJ*

The Week

How many doctors, I wonder, realise that they will have to learn about PDTs, back burners, broken records, and Mr Nasty and Mr Nice to be successful in negotiations? How many, indeed, realise that they may have to get embroiled in negotiations at all? Up to now negotiations about all the major aspects of doctors' conditions of employment have been handled centrally by a few national negotiators—who presumably have known what they were letting themselves in for. With more and more hospitals becoming trusts, however, more negotiations will be done locally—so more negotiators will be needed.

Earlier this month the BMA explained to a gathering of doctors from NHS trusts the importance of setting up local negotiating committees to discuss and safeguard terms and conditions of service for doctors working in trusts (23 November, p 1338). Although they will have the help of full time BMA staff, in many cases it will be doctors themselves who will be advising their colleagues about contracts and negotiating revised terms with trust boards.

The BMA has for many years had place of work accredited representatives (POWARs) and has run regular training courses for them. Now that some of those POWARs work in trusts there is a new edge to their work: no longer are they negotiating within the warm embrace of a nationally agreed framework. For senior doctors at least, trust managers are free to offer what they like and doctors to accept or resist as they see fit. Already rumours are going round one hospital that some consultants have been given personal contracts—one of the conditions of which is that they do not discuss the contents of the contract with anyone else. It may be only a rumour, but it shows how much the climate has changed.

Recently I became a POWAR for the afternoon and joined a group of POWARs to learn about the principles of negotiation, the elements of employment legislation, and how to recognise unacceptable clauses in contracts. I and my fellow negotiators faced an aggressive chief executive who wanted to set up a joint consultative committee representing all staff in his trust. As BMA representatives we demanded—and got—a separate group to negotiate on behalf of the medical staff. Some of those who took the part of the managers felt uncomfortable with the role, yet it is important to know how the other side might be thinking. Moreover, doctors who become medical directors of trusts—and even clinical directors in some cases—may well be negotiating contracts with their colleagues.

We learnt that everyone should have a written contract of employment, even though this is not a statutory obligation. This should include the name of the parties to the contract, the date of employment started, the job title, and details of pay, hours of work, holidays, pension, and grievance and disciplinary procedures. The BMA's industrial relations officers produced several examples where one or more of these items had been left out. During the group work we had to dissect a contract offered to a new consultant in a trust, identify what elements were being left out, and assess whether the extra salary offered was adequate compensation for their loss (it wasn't). Then, back arguing with the "managers," we learnt to deploy the tactics I mentioned at the beginning: how to suggest postponement of an item (putting on the back burner); continually repeating a point (broken record); and deciding who among your negotiators will place the role of Mrs Nasty (banging the table) and Mr Nice (sweet reasonableness). And PDTs? Physical distraction tactics, of course.

HART